Spring 1999 **News At Nine** Vol. 4 Issue 2

TRICARE

Your Military Health Plan

TRICARE SOUTHERN CALIFORNIA

Resource sharing optimizes TRICARE

Office of the Lead Agent, TRICARE Southern California, Region Nine

Inside This Issue

Office of the Lead Agent Key Points-of-Contact

Commercial: (619) 532- DSN: 522-

Director:	
Capt. Kristine Minnick, NC, USN	-5429
Secretary:	
Ms. Linda Wetteland	-5429
Admin	
HMCS (SW) Thomas Denny	-5321
Education and Planning:	
Ms. Martha DeMers	-9697
Public Affairs:	
Lt. Rick Haupt, USN	-5439
Clinical Operations:	
Capt. Kathy Fischer, MC, USN	-6114
Analysis and Evaluation:	
Lt. Col. Dale Villani, USAF, MSC	-6172
Regional Operations:	
Lt. Col.(P) Raymon Sanchez, MSC, USA	-6199
Resource and Contract Management:	
Capt. Bob Engelhart, MSC, USN	-7165
Telemedicine and Technology Assessment:	
Lt. Col. Kerry Larson, USAF, MC	-9388

News At Nine

Lead Agent: Rear Admiral Alberto Diaz, Jr., MC, USN
Director: Capt. Kristine Minnick, NC, USN
Public Affairs Officer: Lt. Rick Haupt, USN
Visual Information Specialist: Mr. John De Leon

Naval Medical Center
TRICARE Region Nine, Suite 400
34960 Bob Wilson Drive
San Diego, CA 92134-6400

News At Nine is an official, quarterly publication of the Office of the Lead Agent, TRICARE Region Nine. Its purpose is to inform Region Nine military treatment facility and support contractor staff about policies and items of interest regarding the TRICARE program. For submission guidelines, contact the PAO at (619) 532-5439 or DSN 522-5439.

ON THE COVER: ***Glenda Joiner, a medical assistant brought into the 61st Medical Squadron at Los Angeles Air Force Base under a resource sharing agreement, works with Senior Airman Eric McFall. Resource sharing optimizes TRICARE in a variety of ways. (Story on page 6)***

From the Lead Agent

Rear Adm. Alberto Diaz, Jr., MC, USN

As we move toward the coming millenium, we find the Military Health System continuing to change at a rapid pace. Indeed, this is a reflection of what the civilian healthcare industry currently faces. Those of us working in the TRICARE system today face even bigger challenges, though, than our civilian counterparts — we need to be prepared to deploy at a moment's notice in support of our national interests.

"We are the only HMO that goes to war," says our MHS leader, Dr. Sue Bailey, assistant secretary of defense for health affairs.

No statement could be more true. We need to remember that our main mission is readiness, and delivery of peacetime health care, in conjunction with contingency support training, is the practice that keeps us ready.

The 1999 Worldwide TRICARE Conference "Wartime, Peacetime, Primetime" brought this reality back to the forefront of our minds, and the ongoing NATO operations in Kosovo should remind us of our greater calling.

In order to meet the demands of military readiness and the promise of delivering peacetime healthcare to our families and retirees, we must continue to move toward a seamless partnership with the private sector. Our goal of integrating our direct care system with the civilian provider network remains paramount. We must to continue to take a leadership role here in Region Nine to illustrate for the rest of the TRICARE system that it can be done.

To this end, one of the best tools have is our resource sharing program. Using resource sharing personnel and assets to complement those in our direct care system is a proven best business practice, and we've got the most successful resource sharing program of any TRICARE region. We currently have 75 active agreements and have saved over $66 million during the first three years of our managed care support contract. Recapturing the former CHAMPUS workload into our military treatment facilities, where we can provide high-quality care at a lower cost, generates these savings. Fundamentally, resource sharing is that simple.

The best part of resource sharing is that it improves customer satisfaction. By accessing their care at an MTF, our customers aren't subject to a copayment or cost share. And as we continue to develop better business and customer service practices, their choice is obvious. They're enrolling in TRICARE Prime at our MTFs.

This is the magic of developing an integrated health system. We provide the right care, at the right time, by the right provider, at the right cost. This is what TRICARE is all about — making our healthcare system efficient for the government and the patient alike.

However, the process of change takes time. In her recent visit to southern California, Dr. Bailey acknowledged this fact.

"We've got to stabilize, simplify and satisfy," she said.

TRICARE in Region Nine is stable. We're further along than the majority of the TRICARE system, having benefited from a rich managed care environment and the CHAMPUS Reform Initiative, TRICARE's predecessor, here in southern California. Our managed care support contract with Foundation Health Federal Services is mature and operating smoothly.

We're continuing to simplify the program through our ongoing marketing and communication efforts. But to satisfy our customers, we've got to deliver the promise. We can do it by engaging in sound business and customer service practices for our customers. While we've made great progress in this area, there is still improvement to be made.

"We've got to get our telephones answered and our appointments filled in a prompt and courteous manner," Dr. Bailey said.

I echo her challenge. We can do better.

Overall, we're doing a great job here in Region Nine. But realize that continuing improvement is key to making TRICARE the health plan of choice in 2000 and beyond. Keep up the great work!

Contractor's Corner

By Peter McLaughlin

The past few months have been particularly important in the evolution of the TRICARE program in southern California. One of the most important parts of our evolving service is the continuing development of TRICARE Senior Prime at Naval Medical Center San Diego. Unique to this development is the growing case management team approach between NMCSD and FHFS for the Senior Prime population.

Senior Prime is now in its fifth month of health care delivery. NMCSD and FHFS case managers are engaging in joint, biweekly meetings to improve quality of care and clinical outcomes for the Senior Prime enrollees.

Case management efforts are targeted to provide optimum care, especially for those afflicted with multifaceted, problematic, chronic diseases or disabilities. The case managers serve as a vital connection linking all the direct care, civilian private and public associations, agencies, disciplines, and practitioners within the health care delivery system. They focus on facilitating the delivery of more individualized, coordinated care for the Senior Prime beneficiary. The NMCSD and FHFS case management team members are catalysts and communicators, advocates for the Senior Prime enrollees, providers, and the overall success of the Senior Prime program.

Case managers are committed individuals who adhere to ethical principles that deliver more cost-effective health care. The team members are working on joint policies and procedures that allow the coordination of medical services resulting in improved quality of care, outcomes and cost effectiveness. The focal point of the case management program is to empower patients, giving them and their families access to a greater understanding of their disability or disease, a larger voice in the delivery of their care, and more personalized attention to their particular needs. The partnering of NMCSD and FHFS has helped patients deal with the complexities of the health care system. The team approach allows the case manager to make objective assessments and coordinate an effective program of care for Senior Prime enrollees.

Mr. Peter McLaughlin, vice president, Foundation Health Federal Services for Region Nine.

Currently, the NMCSD/FHFS case management team is dedicated to the Senior Prime population. However, discussions are already beginning to apply the combined case management approach to all TRICARE beneficiaries residing in the San Diego area. With the assistance of the Office of the Lead Agent, a direct care/contractor combined case management program has significant potential and would benefit all TRICARE beneficiaries.

Military Health System on track for Y2K compliance

WASHINGTON — All Military Health System "mission critical" health systems met the December 1998 deadline of the Department of Defense for Y2K repair and have been certified for compliance.

In addition, 85 percent of the 75 "non-mission critical" systems, and 98 percent of biomedical equipment, have been deemed Y2K compliant. Mission critical systems are those necessary for uninterrupted delivery of medical care. Non-mission critical systems include all other devices supporting effective healthcare delivery and efficient operation of medical facilities.

Goals for March 1999 included achieving Y2K compliance for all remaining computer systems, biomedical equipment and facility systems, such as air conditioning, elevators and security systems in military treatment facilities. Any device that did not meet the March 31 deadline for government-wide compliance will be fully tracked. Non- compliance is primarily caused by manufacturer delays in providing necessary upgrades. Items that cannot achieve compliance will be removed from service. Full compliance for mission critical systems is expected by the end of the summer.

Courtesy of DOD Public Affairs

TRICARE – "Stabilize, simplify and satisfy," Bailey says

By Lt. Rick Haupt, USN

SAN DIEGO – Assistant Secretary of Defense for Health Affairs Dr. Sue Bailey spoke with a number of key TRICARE stakeholders here March 31.

In an effort to exchange information, Bailey participated in several focus groups with southern California area flag officers, beneficiary representatives and military and civilian healthcare providers. In these groups, she offered an open discussion of the current strengths and weaknesses of DOD's four year-old health plan.

Assistant Secretary of Defense Dr. Sue Bailey discusses aspects of TRICARE during a focus group with healthcare providers from the southern California area. She also held focus groups with beneficiaries, civilian providers and line commanders.

"DOD healthcare is remarkably better than it was ten years ago," Bailey said, citing improved technology, provider training and the emphasis on preventive care. "The problem is, it is perceived as more complex."

Prior to the advent of TRICARE, beneficiaries of the Military Health System received care from either military treatment facilities or CHAMPUS-authorized providers. With TRICARE's variety of choices, some beneficiaries have become confused.

"We need to stabilize, simplify and satisfy," Bailey said.

Focus group attendees concurred.

"I think we need to simplify TRICARE, especially for our new service members," said Quality of Life Coordinator Wendy Peterson of the Marine Corps Recruit Depot here.

Quality of care was not an issue in the focus groups. But difficulties with access to care and customer service were repeated themes.

"The quality of health care is top-notch," Bailey noted. "But we need to improve our business practices and change the perception of our customer service. We need to get our telephones answered and our appointments filled in a quick and courteous manner."

Rear Adm. Alberto Diaz, lead agent of TRICARE Southern California and commander, Naval Medical Center San Diego, agreed.

"We are very proud of the quality of care we provide," Diaz said, "and we're continuing to work to improve access through sound business practices."

Bailey's visit here was one of several in a greater outreach effort. Her stop here marks the eighth TRICARE region she's visited in early 1999. She's scheduled to visit the remaining TRICARE regions worldwide by mid April.

Independent studies have shown TRICARE has improved access and quality of health care while containing costs for both the government and eligible beneficiaries in the Pacific Northwest region, where it has been in place since 1995. A similar report on the outcome of TRICARE in the southern California area, where it began in 1996, is expected later this year.

Resource sharing optimizes TRICARE

By Lt. Rick Haupt, USN

LOS ANGELES AFB, EL SEGUNDO – "It's nice to see you today, how are you doing today Doug?" asks Dr. Pat Coleman to recent Air Force retiree Doug Sparks.

In his white lab coat and sharp appearance, Dr. Coleman fits right in with his uniformed counterparts. He is a family practice doctor who serves TRICARE Prime patients at the 61st Medical Squadron here.

Coleman works for Spectrum Healthcare Resources, Inc. under a resource sharing agreement provided by the region's managed care support contract through Foundation Health Federal Services, Inc.

Because the 61st Medical Squadron has the space and support system in place, it is more cost effective for the government to pay for him to provide his skills at the clinic rather than pay for an equivalent service delivered entirely in the private sector through FHFS's network.

Dr. Pat Coleman, a resource sharing physician, checks the ear of recent Air Force retiree Doug Sparks at the 61st Medical Squadron, Los Angeles Air Force Base.

By definition, a resource sharing agreement allows the managed care support contractor to "share" a needed resource – be it a provider, supply or piece of equipment – with the government, when and where needed, when that resource can enable a military treatment facility to better and most efficiently supply a healthcare service to its beneficiary population.

A resource sharing agreement is a contract vehicle that improves the efficiency of the TRICARE program by allowing a greater proportion of patients in an MTF's catchment area to receive care at the MTF. This process, known as "recapturing" workload, provides many benefits to the MTF commander, the government, and the beneficiaries contractor – a "win-win" situation for all.

By bringing Dr. Coleman in to the clinic, the government and the contractor save the higher cost of sending a patient for the same care in a privately owned office. The patient benefits by having more of their health care needs met at the MTF. This saves the patient the copayment due in the civilian network and offers greater continuity of care by keeping the patient at the MTF.

"Resource sharing enables me to build the enrollment of beneficiaries to our clinics," says Col. (sel) Mark Wiszniewski, USAF, NC, commander of the 61st Medical Squadron. "That helps maximize the convenience to the customers and allows them to avoid the copayment required in the civilian network. It helps us widen our umbrella – we don't feel constricted by manning shortfalls on the uniformed side of the house."

"Resource sharing allows an MTF commander to optimize the capacity of the facility," added Maj. Kelly Wolgast, AN, USA, who coordinates resource sharing for TRICARE in southern California. "It helps the commander maintain a well-rounded, robust healthcare delivery system that best meets the needs of the beneficiary population within the MTF's catchment area."

"We've found that resource sharing agreements really improve beneficiary satisfaction because they keep

*See **Resource Sharing**, page 7*

Resource Sharing

continued from page 6

more services at the MTF," Wolgast says. "By getting as many services as possible at the MTF, the beneficiary's convenience is maximized and the copayment that comes with a visit to the civilian network is eliminated."

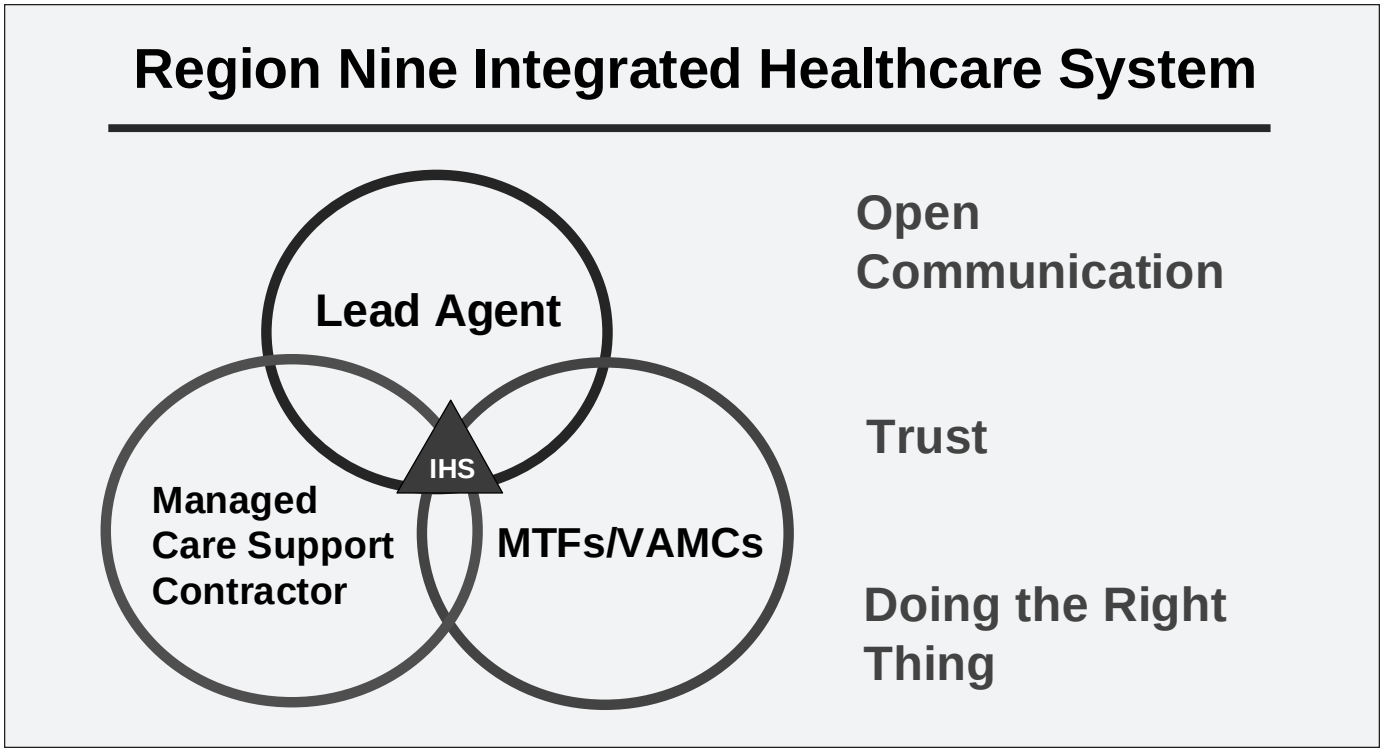
The process for determining resource sharing opportunities is straight forward but based on detailed analysis. A team of people from the MTF, FHFS and the lead agent's office analyze network claims data for the MTFs catchment area. By comparing high-cost treatment outside the government facility and the operational capacity of the MTF to deliver that treatment, they identify opportunities for cost saving. When the projected savings to cost ratio works out favorably for a resource sharing agreement, the MTF drafts a formal proposal, staffs it through Wolgast, who delivers it to FHFS. FHFS then obtains the "shared" resource for the MTF.

Currently, there are 75 active resource sharing agreements throughout the MTFs in the southern California region. The vast majority are for personnel, including over 75 providers.

In the first two years of the five-year managed care support contract in the region, the government saved $20.5M and $22M, respectively. A similar savings is expected for the third year of the contract. For more information on resource sharing in Region Nine, contact Maj. Kelly Wolgast at kawolgast@reg9.med.navy.mil.

Resource sharing agreements impact a military treatment facility's healthcare environment by:

- increasing access to the facility through greater clinical capacity
- reducing claims costs in the catchment area compared to the costs prior to the resource sharing agreement's implementation
- increasing enrollment of Prime beneficiaries to the military treatment facility, resulting in a larger opportunity to direct the high cost tertiary care of the enrolled population



Tele-Home Health Project underway

Region Nine and Strategic Monitored Services' Tele-Home Health Project is off to a running start, having commenced healthcare delivery to nearly 100 adult chronic obstructive pulmonary disease patients and 100 pediatric asthma patients.

The overall goal of the initiative is to prototype a more efficient, effective, and self-sustaining system of health care delivery to chronically ill beneficiaries, and to demonstrate its applicability to other government and civilian health purchasers and providers. It is a "joint venture" between the Department of Defense and private industry. The project objectives are:

- Assess the proposed system's impact on total health care delivery to chronically ill populations.
- Evaluate the adequacy to provide necessary privacy and security for demand-managed, Internet-based patient records, health education, and medical research resources.
- Demonstrate the benefits of physician-customized, disease-specific, clinical protocols and paths for outcome-based, quality assured care.
- Prove the suitability of commercial-off-the-shelf hardware, software, communications infrastructure, and training/support systems necessary to establish an integrated telehealth Internet application for use in military, national and multi-national environments.
- Provide validated data to local, state, national and international health care agencies regarding utilization levels, case mix, and risk sharing with managed care support contractors.
- Provide per capita cost data to TRICARE's bid price adjustment formula, thereby reducing the risks associated with estimating and negotiating future multi-year contracts for health care services.
- Identify and validate human factors in treating the chronically ill using telemedicine-telehealth technology.
- Evaluate the suitability of the orientation training, guide book, and follow-up guidance that are provided to the patients to ensure effective system usage.
- Collect and analyze benefits realization data using the DOD approved "Episode of Care" benefits assessment model.

More information on the project is available at www.reg9.med.navy.mil and www.strategicmed.com.

Courtesy of Strategic Monitored Systems.

TRICARE Senior Prime moves forward

By Cmdr. Dan Wasneechak, NC, USN

SAN DIEGO — Naval Medical Center San Diego's TRICARE Senior Prime program continues to surpass the expectations of both beneficiaries and staff in terms of increased access to care and satisfaction.

Over 2800 beneficiaries have enrolled to one of four Senior Prime primary care locations. The most popular, the Internal Medicine Clinic located aboard the Naval Medical Center campus, is reaching capacity and soon will only be able to accept those TRICARE Prime beneficiaries who "age-in" to Senior Prime upon turning 65.

The good news is that there is still plenty of room at the Primary Care Groups located at the Naval Training Center and North Island Naval Station branch clinics. Those beneficiaries interested in maintaining a primary care provider and/or being squeezed out of "space available" care should consider the benefits of Senior Prime.

More Senior Prime information is available from the beneficiary service representatives at Foundation Health Federal Services at 1-800-979-9620.

Federal Employees Health Benefits Program - 65

Congress passed legislation early this year allowing beneficiaries in certain geographical areas to participate in another demonstration – the Federal Employees Health Benefits Program - 65. Federal policy makers are looking at FEHBP-65 as a mechanism in which military/Medicare-eligible beneficiaries may receive care outside of the direct care system.

Beneficiaries residing in the Camp Pendleton "service" area will be eligible to participate beginning January 1, 2000. Although all of the details have not been finalized, some preliminary information from the is available.

*See **TRICARE Senior Prime**, page 23*

First DoD "Baby-Friendly" hospital named

By 1st Lt. Jana Pettengill, MSC, USA

NATIONAL TRAINING CENTER, FORT IRWIN — The staff of Weed Army Community Hospital celebrated its designation as the first "Baby-Friendly" hospital in DOD during a ceremony here March 31.

Baby-Friendly USA, responsible for implementing the United Nations Childrens Fund's Baby-Friendly Hospital Initiative in the Untied States, designated Weed the 16th Baby-Friendly birth facility in the United States.

The prestigious Baby-Friendly designation recognizes birth facilities that offer breast-feeding mothers the information, confidence, and skills needed to successfully initiate and continue breast feeding their babies.

The Baby-Friendly review team commended the staff of WACH for consistently high scores in breastfeeding management.

"I had so much pride in my staff when we finally received the accreditation," said Capt. EuLynn Harrison, head nurse of the Mother-Baby Unit and the Women's Health Clinic. Harrison is an internationally board certified lactation consultant, a designation that requires that she have at least 2500 hours consulting patients about breastfeeding.

In 1997, the American Academy of Pediatrics issued a policy statement supporting the use of breastfeeding, stating that "breastfeeding ensures the best possible health, as well as the best developmental and psychosocial outcomes for the infant." The Baby-Friendly Hospital Initiative is a global program sponsored by the World Health Organization and the United Nations Children's Fund that adheres to the AAP belief by encouraging and recognizing hospitals and birthing centers that offer an optimal level of care for breastfeeding mothers and their babies.

"Supporting breast feeding just seemed like the natural choice," said Capt. Ann Friedmann, WACH's chief of obstetrics and gynecology. "There is not a better preventative medicine than breast feeding. The physicians here talk to each prenatal patient about breast feeding and make sure they are seen by a lactation consultant."

According to Harrison, all of the babies readmitted for an illness at WACH in 1998 were fed formula before six months of life.

"The most important part of being Baby-Friendly accredited is supporting the family," said Capt. Kim Garcia, certified lactation consultant and registered nurse. "Prenatal education about breastfeeding, supporting moms in post-delivery breastfeeding and having someone available 24 hours-a-day to give assistance or answer questions are all important components of that."

Army Specialists Lanisha and Richard Shearn with son Richard Jr. Lanisha works in a field unit and continues to breast feed after 10 months.

WACH has a number of breast pumps set up on post. There are five pumps in the hospital and a pump set up in the Dr. Mary E. Walker Memorial Center. They also plan to set up a pump at the Marine Corps Logistics Base in the future.

Friedmann attributes the success of the Baby-Friendly designation to the support of the chain of command and the coordination between the physicians, nurses and executive committee.

"Everyone put in a lot of work and personal time into the accreditation process. We were all required to have 18 hours of instruction," said Spec. Marty Contreras, a licensed practical nurse.

"Now that we have received the accreditation, we plan to develop a way to serve as a reference and tell other hospitals how we did it," Friedmann said.

Further information about the Baby-Friendly program may be obtained by calling (508) 888-8092 or faxing (508) 888-8050. Their address is Baby-Friendly USA, 8 Jan Sebastian Way, Sandwich, Mass. 02563.

New director reports aboard TRICARE Region Nine

By Lt. Rick Haupt, USN

SAN DIEGO — Navy nurse Capt. Kristine Minnick reported aboard the Office of the Lead Agent, TRICARE Southern California, Region Nine, here April 5 to serve as director.

Capt. Kristine Minnick NC, USN

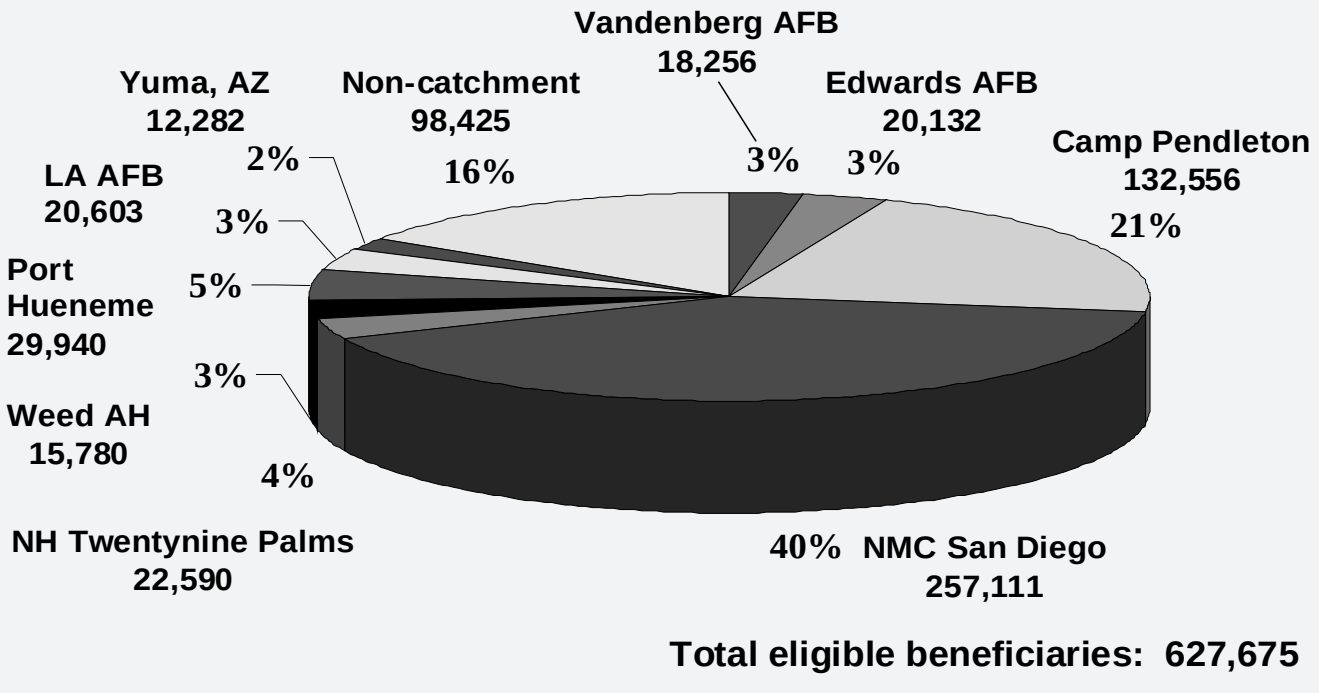
Minnick reported to Region Nine following her assignment as director and chief of staff at TRICARE Pacific Northwest, Region 11, from 1996 to the present. Her service at Region Nine follows that of Capt. John Shore, MSC, USN, who left Region Nine in February to assume duties overseeing TRICARE Regions Two and Nine, the two Navy-run TRICARE regions, for the Navy's Bureau of Medicine and Surgery.

"Kris brings a wealth of knowledge and experience to Region Nine," said Capt. Shore. "She was directly involved in the success of Region 11 and will bring a very welcome leadership style to Region Nine."

Prior to serving as director and chief of staff at Region 11, she held the positions of director, Nursing Services at Naval Hospital, Yokosuka, Japan; assistant for Administration Services and assistant director, Ambulatory Nursing at Naval Medical Center San Diego; and head of Nurse Corps Education Programs, Naval Health Sciences Education and Training Command, Bethesda, Md. As a junior officer, she served as a staff and charge nurse in a variety of hospital departments at duty stations in Oakland, Calif.; Great Lakes, Ill.; Portsmouth, Va.; and Orlando, Fl.

Minnick earned a Master of Science Degree in Nursing Health Services Administration from the University of Michigan, Ann Arbor, in April 1983.

Region Nine beneficiaries by MTF

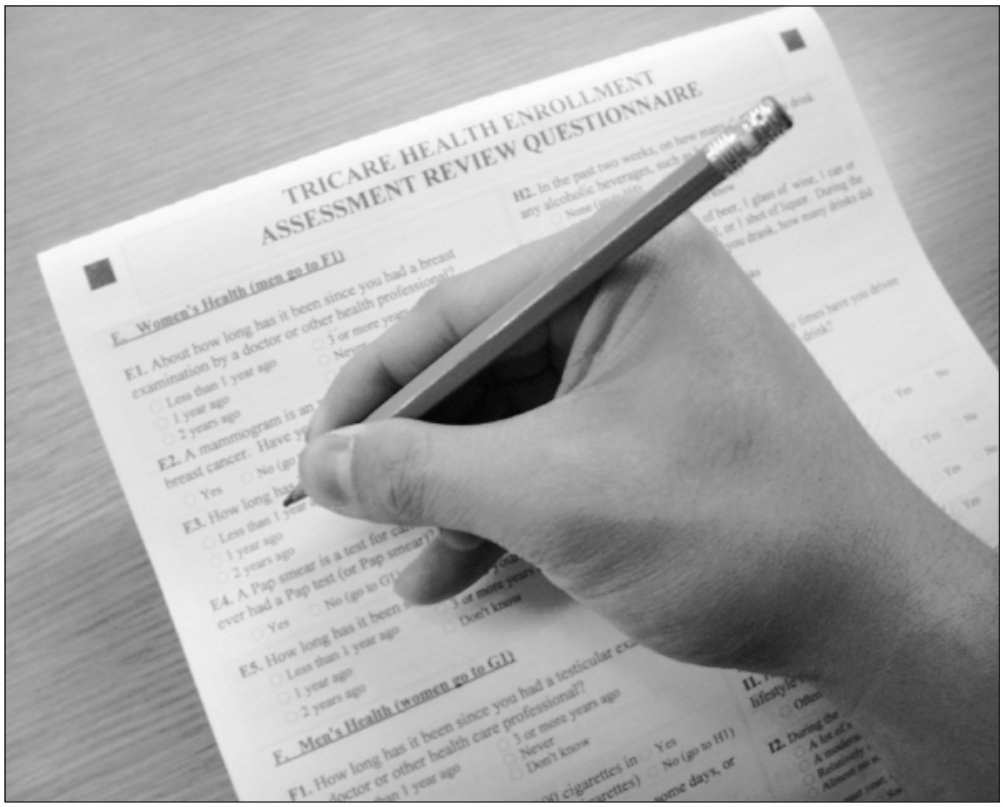


HEAR now in use

By Cmdr. Julie Kirkpatrick, NC, USN

The Health Enrollment Assessment Review, a managed care tool to track the health of our beneficiaries, is now in use in Region Nine.

Implemented in early 1998, the HEAR database has grown large enough to begin basic trend analysis and quality verification. As a healthcare resource management tool, the HEAR survey provides information to the lead agent's office on the health status of the region. Having a regional overview of the health status of our beneficiaries allows us to take a population-based approach to planning disease management and health promotion programs.



All active duty members, retirees and family members should be encouraged to complete a HEAR questionnaire. Doing so will help us best manage their health.

At the primary care level, the HEAR data provides the primary care manager with information on the individual health care needs of a particular patient. For the beneficiary who completes a HEAR survey, an individualized summary of their preventative health care needs, and a list of their risk factors is mailed to their home. This information allows the beneficiary to be proactive in obtaining preventive health care services.

There are several programs available to assist the lead agent's office and military treatment facilities sort through HEAR data. The easiest of these to use are ACCESS-based programs, which are government owned. There is no cost to MTFs to install these programs at their facilities. These programs provide easy maneuverability of the data to look at pertinent clinical findings. Providers can look at health promotion, prevention, disease management and demand management issues at the click of a mouse. All who have worked with the databases and reports have found them extremely user friendly.

Validity checks for seven criteria appear to work appropriately and identify reporting errors such as males reporting Pap tests. Single factor clinical information such as how many active duty individuals smoke is easily obtainable, but multi-factor cross referencing to identify those smokers who also report high blood pressure still has technical limitations. New version of the database, due out soon, will hopefully strengthen that area of the database.

The database programs are work in progress — they are not perfect. Verifying the data's accuracy is an on-going endeavor and any problems encountered with the program should be reported to your HEAR program coordinator at your MTF.

For further information on the HEAR program or to set up training on the database, please contact me, CDR Julie Kirkpatrick, at (619) 532-6193 or jmkirkpatrick@reg9.med.navy.mil.

Spotlight on the 61st

Small clinic serves base personnel and a whole lot more

By Lt. Rick Haupt, USN

LOS ANGELES AFB, EL SEGUNDO – Nestled in the sprawl of one of the nation's largest metropolitan areas here is a small staff of Air Force medical professionals dedicated to providing the highest quality primary healthcare possible to the U.S. military's active-duty servicemembers, retirees and their families.

Air Force Tech. Sgt. Richard Miller, a lab technician runs samples through a blood chemical analyzer at the 61st Medical Squadron.

Comprised of only 128 personnel, they serve an eligible beneficiary population of over 40,000 in a twenty-mile radius of the base. They meet the demand of this daunting mission and a do whole lot more. One of the more notable parts of their mission is serving a large number of servicemembers who aren't part of the Air Force.

"We've got a very diverse population in terms of military service association," says Lt. Col. Gregory Parrish, USAF, MSC, the squadron's deputy commander. "We get people with all colors of uniform coming through here on a daily basis. If you go into the waiting room during sick call, many times you'll see Air Force uniforms to be in the minority."

In fact, the Army supplies nearly 25 percent of the beneficiaries in the squadron's catchment area, with the Navy, Marine Corps and Coast Guard population supplying nearly an equivalent combined amount.

Additionally, the squadron serves other federal government agencies such as the FBI and Public Health Service by providing overseas screenings and immunizations for their personnel departing the United States on special missions.

The base itself, adjacent to Los Angeles International Airport, consists of scattered compounds mixed in with high-tech engineering firms, many of them defense contractors. One of the functions of the base here is to liaison with the industry that supports Air Force missile programs. The base's largest component is the Air Force Space and Missile Systems Center.

With base housing located over 20 miles away and affordable off-base nearly non-existent nearby, the squadron is challenged to extend its reach to deliver care to its families that are attached to the base. Increasing the challenge is the wide variety of military units not associated with the base, such as ROTC units, recruiting stations, and retirees scattered about the greater Los Angeles area. Add in a number of retired beneficiaries who travel from the areas near recently closed bases such Norton AFB, March AFB and Long Beach Naval Station, and you've got one of the most unique and diverse beneficiary populations served by a DOD facility anywhere.

The 61st Medical Squadron is committed to:

- its customers
- its people
- sound business practices
- health promotion
- technology
- facilities

Medical Squadron

The squadron's facility also provides its staff challenges. Never designed as a clinic, it first served as an aircraft engine test facility during the 1960s. It was converted to a contract administration site in the 1970s and finally assumed its current role as home to the medical squadron in the 1980s.

Construction on a new home to the squadron will commence in fiscal year 2000. A new and revolutionary design, it is known as a "clinic of the future."

To meet the needs of its base families, the squadron operates a remote clinic at Fort MacArthur, a former Army facility located 20 miles to the southwest. It proves to be a major satisfier among TRICARE beneficiaries.

"The families love the clinic and doctors at Fort MacArthur," says Pauline Triebenbacher, TRICARE representative for Foundation Health Federal Services, who supports the squadron in its efforts to market the TRICARE benefit. "It's really convenient and the personnel there are just great."

But the challenge of getting from other parts of the dense metropolis to either facility provides for additional complications.

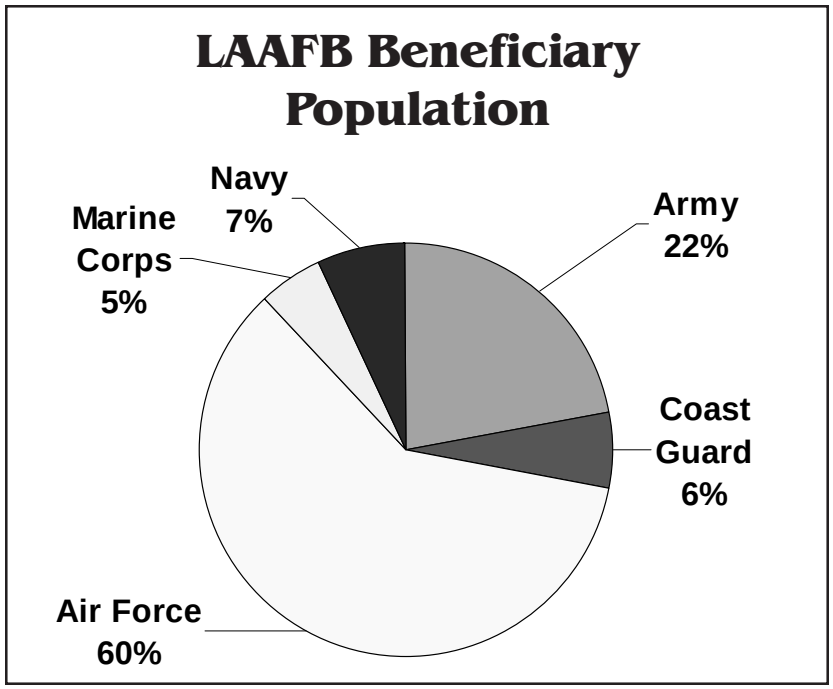
"Traffic here can be nearly unbearable at times," says Capt. Jami Reaves, USAF, MSC, director of managed care at the squadron.

However, along with the challenges of the urban environment comes a boon, too – namely the robust civilian provider network that offers many options for primary, specialty and ancillary care.

"The support from our TRICARE contractor, Foundation Health, is phenomenal," says Squadron Commander Col. (sel)

*See **61st Medical Squadron**, page 14*

Pharmacists Capt. Dawn Coley, USAF, MSC and Roya Nourmand-Tavari work to keep the stock of medications flowing at the 61st Medical Squadron.



Tech. Sgt. Alan Ridge, radiologic technologist is a strong supporter of improved customer service and the Air Force Surgeon General's "Skunkworks" customer service program.

61st Medical Squadron

continued from page 13

Mark Wisniewski, USAF, NC. "Their network is huge, and there are major medical centers all around."

The robust network also pushes the clinic to provide the best service possible, providing a competitive environment in terms of cost, customer service and convenience.

"The network provides us with competition," says Air Force Tech. Sgt. Alan Ridge, a radiologic technologist at the squadron. "The customers are our bread and butter. If we don't treat them right, they'll go somewhere else."

Ridge noted the Air Force surgeon general's "Skunkworks" customer service program as a move to meet the demands of the competitive environment. Introduced to the squadron in 1998, Skunkworks helped the squadron's personnel focus on the needs of its customers and improved performance in many ways.

"The program taught us to let our patients know that we're here for them – it reinforces the right attitude," said Ridge, a 16-year veteran. "It's a lot different from the old days, and that's a real change for the better."

Skunkworks – the basics:

Core Values:

Integrity first
Service before self
Excellence in all we do

IMPRESSION:

I = Continually improve my job knowledge and performance, and daily apply lessons learned.
M = Be a positive role model/mentor for exceptional customer service.
P = Take pride in myself and work area.
R = Cheerfully acknowledge all customers and treat them with respect, honesty, and compassion.
E = Escort, rather than point, when helping others find their way.
S = Speak with a smile and always address others by name.
S = Do everything possible to provide hassle-free, one-stop service.
I = Be assertively friendly, taking the initiative to help when someone is confused or upset.
O = Own a customer's concern until it is satisfactorily addressed.
N = Seek to understand my customers' needs, and through teamwork, pursue creative ways to exceed expectations.

This *newfangled* thing called managed care

By Martha DeMers

It might surprise you to know that forms of what we know as "managed healthcare" have been around since early this century.

The Western Clinic in Tacoma Washington is often cited at the first example of a prepaid group practice, or health maintenance organization. In 1910 the providers of the Western Clinic offered a broad range of medical services to lumber mill owners and their employees for 50 cents a month. The primary purpose of this deal was to assure the clinic of a good flow of patients, and revenue. Similar programs were started and expanded across Oregon and Washington.

In 1929 a rural farmer's cooperative health plan was started in Oklahoma. In exchange for purchasing shares in a new hospital for $50 each farmers received discounted medical care. The physician who designed this program was kicked out of the county medical society and threatened with suspension of his medical license. Twenty years later he was vindicated in an out of court settlement of his anti-trust suit against the country and state medical societies.

Nineteen twentynine is also the year that health insurance appeared on the scene when Baylor University, in Texas, agreed to provide teachers prepared care at its hospital. Dallas schoolteachers received up to 21 days of free hospital care for their 50 cents a week premium. This program was eventually expanded to include other employers and hospitals and ended up growing into the familiar Blue Cross. Starting in 1939, the medical society in California, and some other states, started statewide programs to reimburse for physician services – which became Blue Shield. Today, Blue Cross/Blue Shield plans cover approximately 73 million people.

It is interesting to note that the formulation and promulgation of all these programs during the depression was not driven by consumers seeking to be able to obtain health care services, nor by non-physician entrepreneurs out to develop a market niche. Physicians who wanted to protect and enhance their patient revenues drove these programs.

During the period of time surrounding World War II, several HMOs that are still among the leaders today were formed, with the impetus coming from employers, providers, consumers, and even a housing lending agency seeking to reduce the number of foreclosures due to large medical expenses. Examples of these early HMOs include: Kaiser Foundation Health Plans (1937), started by the Kaiser construction company; Group Health Association (1937), started by the Home Owner's Loan Corporation; Health Insurance Plan of Greater New York (1944), started by New York City for it's employees; and the Group Health Cooperative of Puget Sound (1947), started by consumers in the Seattle area.

Why, then, does the notion of managed care seem new? Perhaps because even though these managed care models had their start early in this century, in 1970 the total number of HMOs was still under 40. These days the number of HMOs and other managed care plans is exponentially higher than 40, and the number of enrollees is above 50 million. At least another 50 million people are enrolled in preferred provider organizations, and approximately 66% of insured employees in firms with more than 10 employees are enrolled in managed care organizations of some type. Compared to some of these managed care organizations, TRICARE is definitely the new kid on the block!

Want to know more about managed care? Go to the web.

http://trochim.human.cornell.edu/gallery/blakesle/mcintro.htm An overview of the history of managed care in America.

http://www.hiaa.org/cons/choosing.html The Health Insurance Association of America's web site contains an explanation of how different types of managed care plans work and defines many of the terms used in the managed care and what they mean for consumers.

http://www.ahcpr.gov/research/mgdnote1.htm This page describes recent research projects about managed care which have been supported or conducted by the Agency for Health Care Policy and Research (AHCPR).

DoD seeks funds for senior's health care commitment

By Douglas J. Gillert
American Forces Press Service

WASHINGTON — The Defense Department wants to make sure all people eligible for health benefits get the care they need, including those age 65 and over, a senior health official said here Feb. 2.

Speaking at the 1999 TRICARE Conference, Mary Gerwin said DoD is committed to providing health care to all eligible retired service members and their families, but it has to find a way to fund the care. She said the group represents the fastest growing segment of the DoD beneficiary population, and DoD is looking at several options for their health care.

"The number of retirees is growing disproportionately to active duty," said Gerwin, a senior adviser to DoD health chief Dr. Sue Bailey and former staff director of the Senate Committee on Aging. She said there are 1.3 million military retirees over age 65 today and the number will rise to 1.6 million by 2005. Since 1994, over-65 retirees have increased 5 percent while the active duty population has decreased 12 percent, she said. Retirees over 65 represent "more than 50 percent of Military Health System beneficiaries," she said.

Federal statutes prohibit staffing military hospitals to treat patients 65 and older, who also are eligible for Medicare benefits. Military treatment facilities can only provide over-65s with space-available health care. Even as the over-65 population is rising, however, space-available care has been shrinking due to base closures and reduced clinic and hospital capacity.

Compounding cost issues, most retirees living close to military facilities depend on space-available care and don't have separate health insurance, Gerwin said. "They benefit from the free prescription drugs, even when they don't use the military treatment facility for their primary care," she said. Medicare doesn't cover outpatient drugs.

The department currently is looking at several ways to deliver care to its elderly population. These include a three-year demonstration of Medicare Subvention in six geographical locations; Medicare will reimburse participating military hospitals that enroll over-65 patients in TRICARE Senior Prime. About 22,000 seniors enrolled to take part in the test.

"We will be able to use Medicare reimbursement to leverage and expand care we deliver to over-65s," Gerwin said. However, she said, some seniors may not want to enroll because the demonstration will last just three years. If DoD doesn't adopt the plan, retirees would have to pay higher premiums to rejoin Medicare Plan B.

Retirees also can enroll in Medicare health maintenance organizations rather than risk losing temporary military health benefits, she said. DoD has matched the benefits offered by Medicare HMOs. "Once we get them in, we're hooked for all their Medicare-based care," Gerwin said. "We have to be able to deliver these benefits" — home care, for example.

DoD recently announced a second demonstration at eight sites. Up to 66,000 over-65 retirees and eligible family members will be allowed to enroll in the Federal Employees Health Benefits Plan.

The Office of Personnel Management will negotiate with the plans and carriers, and enrollees will receive information this summer, Gerwin said.

Two other demonstrations beginning Jan. 1, 2000, will begin supplemental TRICARE coverage at two sites and will expand pharmacy benefits to retirees over 65 in selected areas,
including use of a national mail order pharmacy.

Each of these programs comes at a cost, Gerwin said, with the FEHBP option being the most expensive at $1.4 billion to $1.6 billion a year. Estimated annual costs are up to $300 million for the pharmacy plan and $600 million for the TRICARE supplement, she said. The figures are based on estimates of participation rates and a cost analysis provided by CNA Corp., which has done other studies of DoD health care programs.

Gerwin said she doesn't think DoD can expect more money from Congress, but it would, instead, need "a major pull down in our system" to pay for something as costly as the federal employees plan. She said the costs of the pharmacy benefit could mean larger co-pays for name-brand drugs and higher charges to other beneficiaries. "Or Congress could just put us in the OPM budget."

Leaders unfold plan to modify, strengthen TRICARE

By Douglas J. Gillert
American Forces Press Service

WASHINGTON — Defense health officials unfolded bold new ideas for making sure TRICARE works as planned to deliver quality health care in peace and war. The result could mean more care in-house and less from contractors.

Addressing the 1999 TRICARE conference here, DoD health chief Dr. Sue Bailey and others laid out a plan to address shortcomings in the managed health care plan. In the past six months, a group of Army and Air Force colonels and Navy captains has put together a scheme to re-engineer TRICARE administration.

Dr. Sue Bailey

Navy Dr. (Capt.) Donald Arthur, assistant chief of health care operations for the Navy Bureau of Medicine in Bethesda, Md., and a member of the re-engineering team, said the effort represents a complete "change of culture." He presented the plan Feb. 1 to several hundred TRICARE providers and administrators gathered here from around the world to discuss ways to fine-tune the health plan.

The tri-service group's model ties staffing at military hospitals and clinics to their readiness mission. The facilities must have sufficient staffing to meet wartime requirements, he said, but they also must be augmented by available resources — presumably a mix of civilian contract and military providers — to meet peacetime requirements.

TRICARE was set up with the idea of complementing military resources with civilian contractors, so the plan doesn't seem like such a big change. But Bailey, assistant secretary of defense for health affairs, pointed out military resources are sometimes underused when DoD relies too much on contractors. She said that's going to change, beginning with the mostly contracted appointment system.

"I've initiated a review of the ratio of direct-care [in-house] phone awareness vs. contract," Bailey said. "I don't think we need to contract as much out." She said she plans to shifting functions back to the military is part of a larger effort to keep the promise and to restore members' trust in military medicine.

Bailey said the military has always provided quality health care to battlefields but hasn't been as faithful toward families. She there are inexorable links between wartime and peacetime medicine, including a well-trained medical team, a healthier, prevention-oriented beneficiary population and good information management.

"We are the HMO that goes to war," Bailey said. "We need our bills paid, our phones answered and our appointments made." She said TRICARE's success depends greatly on improving the overall health of beneficiaries, of tracking their health through better recordkeeping, and through responding to patient concerns and perceptions.

"Perception is reality. We need to simplify the message, make our system user-friendly and keep congressional leaders informed of the link between peacetime and wartime health care," she said. And one old perception of military medicine she doesn't want TRICARE to repeat is that it's "better than nothing."

"I want military medicine to be better than everything," Bailey said.

TRICARE Management Activity Director James Sears said the reengineering plan will enable TRICARE to reach its full potential. He said the necessity for change is absolute.

"There are many threats to dismantle TRICARE," Sears said. He said TRICARE administrators must figure out how to move military medicine "from sick call to managed care to a healthy population." Sears challenged the medics to build a more effective organization.

"We have it in our grasp," he said, "to make TRICARE work."

TRICARE Service - Still room to grow

By Douglas J. Gillert
American Forces Press Service

WASHINGTON — Military medicine boasts some of the best doctors, facilities and care available anywhere, but that's not good enough, DoD's top personnel official told health care managers here Feb. 4.

"Ten years hence, people will come together and say, 'What a tremendous system we have, but there were growing pains in the process,'" said Rudy de Leon, defense undersecretary for personnel and readiness, at the annual TRICARE conference. The military health system, he said, still has to improve how and when patients receive care, how people learn about their health care options, and how and when bills are paid. And, de Leon insisted, DoD has to fulfill its commitment to care for retirees age 65 and older.

Rudy de Leon

Health care is important to service members' quality of life and is one of their greatest concerns, de Leon told the worldwide gathering of military and contract medics. "Our challenge in 1999 is going to be to take important steps forward that will restore people's confidence in their health care," he said.

TRICARE, DoD's managed health care plan, is up and running nationwide. Now, de Leon said, it must ensure beneficiaries receive easily accessible and hassle-free care. "As I talk with our beneficiaries at home and on deployment, a common theme emerges," he said. "Active duty members and their families are pleased with the quality of health care they receive. The problems exist in the level of service."

To learn more about patients' problems with TRICARE, de Leon has conducted town hall-style meetings across the country. He said most of the comments he hears fall into two categories: how long it takes to get through on the telephone to make an appointment, and the times patients have had to deal with their whole bill because the doctor hasn't been paid. Health care providers also focus on the claims process, he said.

Unpaid medical claims are a particular concern,

"Ten years hence, people will come together and say, 'What a tremendous system we have, but there were growing pains in the process,'" said Rudy de Leon, defense undersecretary for personnel and readiness, at the annual TRICARE conference.

de Leon said. TRICARE-contracted civilian doctors expect their patients to pay when the government is late.

"To be successful, we must be credible in the promises that we make to both beneficiaries and providers," he said. "Together, we must resolve that the system will not allow young military families to be hounded by bill collectors or surprised by out- of-pocket costs. And we must do all we can to pay our health care providers on time so that the best civilian doctors and other health care professionals will want to participate in the TRICARE system.

"We have first-class people in our system, we have first-class facilities. One thing we can all pledge for 1999 is that we will have a first-class claims process."

Improving the appointment system is critical, de Leon said, so "beneficiaries do not have to spend their time on the telephone making appointments or wait several weeks to get an appointment."

De Leon said people need to know as much about TRICARE as posible. "We have to do more work on educating our beneficiaries on how TRICARE works," TRICARE has improved military health care, he said, but it doesn't do any good if nobody knows about it or how to use it, he said. He urged medical facility commanders to tell their line leadership, senior noncommissioned officers and patients what they're doing locally to improve health care delivery.

"Engage your community," he said. "These are your neighbors and our people that you're working for.

"We've got to keep the message simple, ensuring service members and their families that TRICARE is there for them in times of need."

That message must extend as well to Medicare-

*See **TRICARE Service**, page 19*

Reimer challenges medics to get TRICARE right

By Douglas J. Gillert
American Forces Press Service

WASHINGTON — TRICARE is fundamental to military readiness and quality of life, so let's get it right, Gen. Dennis Reimer said Feb. 1 at the annual TRICARE conference here.

Because the managed health care plan is so important, the Army chief of staff said, DoD must fine-tune it, from improving access to making sure service members and their families receive the highest quality "cradle to grave" care available.

Reimer said TRICARE must meet the standards it was set up for. He cited Army inspector general complaints and a recent survey in the Pacific Northwest as good measures of how far TRICARE has come and, similarly, how far it has yet to go to meet acceptable standards. Although only five percent of Army IG complaints are about TRICARE, he said, "every one of those complaints is a horror story."

Reimer also noted results of TRICARE surveys, particularly one in the Pacific Northwest, that showed high, but not 100 percent, satisfaction with the health plan.

"We have to make sure that we are not satisfied with standards that only address 75 percent of satisfaction," he said. "That's not going to cut it in today's Army. Our soldiers are entitled to better than 25 percent failure.

"Don't rest on your laurels just because 89 percent of claims are processed within 30 days," he told the worldwide gathering of health care providers and administrators. "We must attack the other 11 percent, because those 11 percent are critical to us."

Gen. Dennis J. Reimer

Reimer also urged medical leaders attending the conference, including defense health chief Dr. Sue Bailey, to make sure recruiters and others assigned to remote locations aren't left out. He said delivering health care to them is DoD's most difficult challenge. "If we can solve that, we'll solve the rest," he said.

"If we're not going to be able to provide those people the quality of life they deserve — they're entitled to — then we're not going to be able to have the readiness of the force that we really need," Reimer said. "We recognized many years ago that quality of life is an integral part of readiness. It's not just training, it's not just equipment, but it's how you treat soldiers, how you provide for the care of their families, that is terribly important."

Reimer said TRICARE has tremendous potential. He applauded the efforts of the medics to bring TRICARE on line, but challenged them to concentrate on what needs to be fixed. "We've got to get it right," he said, "because it is so critical to us."

TRICARE Service

continued from page 18

eligible retirees and family members 65 and older, de Leon said. The challenge of finding space and funds to cover the cost of elder care "is going to be with us well into the next century," he said. "We've got to work to make sure we keep faith with our military retirees."

In five years, retirees 65 and older will outnumber active duty beneficiaries in the military health system, de Leon said. He said he's encouraged that Congress will support Medicare Subvention, a Medicare reimbursement program currently being tested at selected military hospitals. He said several senators have told him they support a more inclusive system, allowing retirees to use their Medicare dollars in military treatment facilities.

"We still have a long way to go to meet the commitment for health care that all of our people expect," de Leon said. "But I look out at this audience, and I see the caliber, professionalism and the dedication that exists. You provide very precious benefits both in times of war and peace — gifts of healing and caring. Thank you and I salute you for all that you do."

TRICARE: Friend or foe?

By Lt. Rick Haupt, USN

The answer is friend, of course. What else would you expect from a TRICARE public affairs officer? But as a fellow servicemember and TRICARE beneficiary, I answer "friend" seriously.

TRICARE has been challenged by public opinion as it implemented managed care support contracts across the country from the Pacific Northwest in 1995 to the Mid-Atlantic and Northeast regions in 1998. Make no mistake, TRICARE is managed care, a term commonly tied to health maintenance organizations. HMOs have taken a number of spears in the recent heated national debate over healthcare reform, and those who relate HMOs to cost cutting fear them decreasing the quality of health care.

But what's not often heard in the press is that managed care has won over the healthcare marketplace. Employers, those who pay for the majority of health care in the United States, have found managed care organizations successful in not only containing healthcare costs, but decreasing work absences through the improved health of their employees. Similarly, surveys show the majority of patients in managed care organizations to be satisfied with their health care. Experts who've studied the healthcare industry – the largest service industry in the United States – credit managed care with slowing the rapid acceleration of healthcare costs in recent years.

So why all the fuss over managed care? Think about it: as employers and patients benefit, the "old" profiteers lose. Stakeholders in the squeeze of increased efficiency and change in the new managed care industry include independent providers, pharmaceutical companies and medical equipment suppliers. No longer do their profits come easy as they once did. Do these stakeholders have lobbyists and PR folks out there working hard for the interests of the old system? You bet they do – and they're darn good at their business. It's amazing how a few anecdotes with focused PR can taint an industry.

Like managed care in the civilian world, TRICARE has made significant headway in improving access to quality care while containing costs for military leadership and service members alike. Just as it has aggressively instituted other changes, the Department of Defense completed the implementation of TRICARE managed care support contracts in the radically short timeframe of three years. Compare that with the decades that the civilian healthcare marketplace has taken to evolve into one dominated by managed care and it becomes clear how a few hiccups during implementation could occur.

Employers have found managed care has decreased absences through improved health.

We've all seen the bad press, heard the complaints and perhaps experienced first-hand the pitfalls of long telephone waits for appointments, claims problems and civilian physicians dropping out of contracted networks. But these and many other issues with TRICARE have already been or are in the process of being addressed and fixed.

The first in a series of studies on the effects of the TRICARE program was completed and released in 1998 by the Center for Naval Analysis and the Institute for Defense Analyses. The results of the study showed statistically significant improvements in terms of access, quality and cost – the major parameters by which healthcare plans are compared – while comparing military healthcare under the military's "old" system of military hospitals and CHAMPUS, to the new system, TRICARE, which effectively combined the two while implementing a managed care approach.

It's easy for anyone, PAOs included, to jump on the bandwagon of negativity during a time of change. But understanding the source of the negativity toward managed care will, hopefully, preclude our acceptance of the negativity we read in the press and what we hear on the street. More importantly, we need to understand that TRICARE is indeed attaining the goals our leadership defined for it. It is not a compromise designed to maximize savings at the expense of good health care. Rather, it maximizes savings through enhanced healthcare delivery, patient education, investment in preventive medicine practices, and a more efficient organization. TRICARE has resulted in a healthier population and has significantly improved access.

The success of TRICARE leads to improved military readiness and quality of life. As corporate America called for change in health care decades ago, our leadership called for it too, only more recently and under a much tighter timeline. We need to keep this factor in mind and support TRICARE in making it what we want it to be – the best care available to keep our troops fighting and our families and retirees healthy.

Data quality essential to good management

By Lt. Cmdr. Peggy Cox, MSC, USN

In recent years, the military has begun looking at health care services that demand special attention because of high volume, high clinical and medical-legal risk and costs, as well as impact on a person's ability to return to active service. Variations in medical care, unnecessary hospital bed days and other utilization issues are just some of the system's major concerns.

Incomplete and incorrect data can have a profound effect on military treatment facility operations. It effects day to day business decision making and strategic planning in respects to financial resources, staffing, services available and level of care to name a few. Incorrect data can lead to bad decisions adversely affecting enrollment based capitation funding calculations, the distribution of inaccurate information to leadership, or the underestimation of total due from third party collection programs.

TRICARE Management Activity is taking a proactive stance to improve the overall quality of the data needed for decision making.

"The conversion of the Military Health System to a managed care environment has created the need to adopt new and innovative business practices that are data driven," explains TMA Executive Director H. James T. Sears, M.D. "Data quality is the basis for developing the good business practices necessary to provide a superior health care benefit for our beneficiaries, while honoring our fiscal responsibility to taxpayers."

Richard Guerin, director, Health Programs Analysis and Evaluation at TMA, explains that data collection will be more correct, timely, accurate and complete. The various information systems at military treatment facilities will be integrated and data collected for business analyses will be standardized, including financial, clinical workload and enrollment statistics. The emphasis on data quality also will help ensure that reliable information is provided for audits by the Inspector General and the General Accounting Office, and that DOD can meet requirements to receive reimbursement under Medicare subvention.

Initially, the TMA data quality team will focus on the Composite Health Care System, the Ambulatory Data System, and the Medical Expense and Performance Reporting System. There will be greater emphasis on internal management and business practices that include standardization of data quality and increased training of managers. In the future, managers will find many of their program updates and training programs on the TMA website. Information concerning the web based CEIS data quality training can be obtained by contacting Mr. Tom Lonsdale, at (210) 295-8904, DSN 421-8904 or lonsdalt@vrinet.com.

Joe Marasciullo of the lead agent staff works hard to ensure quality data for Region Nine.

Command level initiatives should include the identification of a data quality manager and involvement of key players in managed care, resource management, patient administration, credentialing and information systems department. The development of a regional data quality working group is integral for ensuring relevant quality data for decision making through integration of the efforts of the MTFs who are responsible for and have a stake in data quality.

Our management information systems, like CEIS, are only as good as the underlying data provided from your health care institution. Our beneficiaries and leadership demand that we function as an efficient and accountable integrated healthcare delivery system. Management decisions must be based on timely and accurate data. Ultimately, every staff member at your MTF is responsible for data quality.

Website data quality information sources include:

- EBC - ww2.tricare.osd.mil/ebc/rm/rm_home.html
- PASBA - pasba/tricare.sod.mil/pasba/dqfas.html
- CEIS – www.ceis.ha.osd.mil

For more information on Region Nine's data quality initiatives, contact Lt. Col. Villani at (619) 532-6172, DSN 522-6172, or dvillani@reg9.med.navy.mil.

Congratulations to DoD Customer Satisfaction Survey Winners!

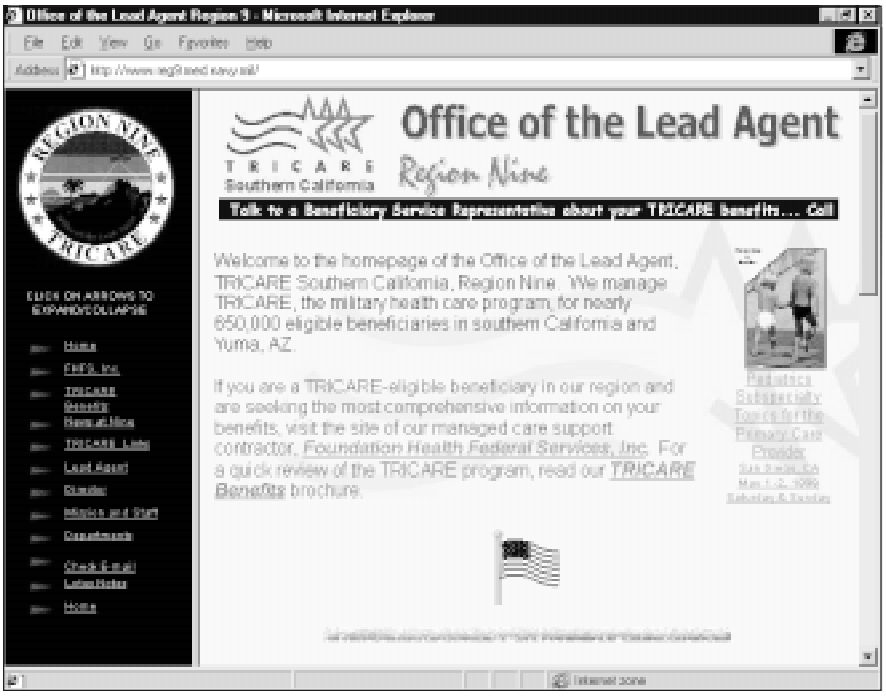
Top 10% of military treatment facility clinics worldwide (4th Quarter FY98 results)

Outstanding Medical Care

30th Medical Group, Vandenberg AFB
Flight Medicine Clinic
95th Medical Group, Edwards AFB
Physical Therapy Clinic
Naval Hospital, Camp Pendleton
General Surgery
Occupational Therapy Clinic
Ophthalmology Clinic
Optometry Clinic
Pulmonary Disease Clinic
Naval Hospital, Twentynine Palms
Internal Medicine
Naval Medical Center, San Diego
Cardiology Clinic
General Surgery Clinic
Hematology Clinic
Oncology Clinic
Ophthalmology Clinic
Otolaryngology Clinic
Weed Army Community Hospital
Orthopedic Clinic

Outstanding Customer Service

30th Medical Group, Vandenberg AFB
Flight Medicine Clinic
95th Medical Group, Edwards AFB
Optometry Clinic
Physical Therapy Clinic
Naval Hospital, Camp Pendleton
Cardiology Clinic
Chiropractic Clinic
Dermatology Clinic
Occupational Therapy Clinic
Naval Hospital, Twentynine Palms
Gynecology Clinic
Naval Medical Center, San Diego
Community Health Clinic
Hematology Clinic
Oncology Clinic
Ophthalmology Clinic
Weed Army Community Hospital
Pediatric Clinic



www.reg9.med.navy.mil

SAN DIEGO - The Office of the Lead Agent, TRICARE Southern California's world wide web site brings a new, expandable communication channel to beneficiaries, military treatment facility personnel and TRICARE contract support staff.

Many features are built into the site, including information on TRICARE benefits, a web version of the *News At Nine,* links to other TRICARE sites, links to all MTFs in Region Nine, and information from Region Nine leadership and departments.

Check it out at http://www.reg9.med.navy.mil and be sure to add it to your web browser's bookmarks.

Region Nine Annual TRICARE Conference "Preparing for the Millennium" May 25 – 27, 1999

San Diego Concourse Convention Facility
Downtown San Diego

Target audience – mid-level managers and providers
Addressing technologies and tools to help meet the needs of the future.

Topics include:

Keynote presentation by Dr. Sue Bailey, ASD(HA)
Managing for Success – Survival Analysis for your MTF
Disease Management
External sources of funding / grant writing
Customer satisfaction

Registration and more information at www.reg9.med.navy.mil

TRICARE Senior Prime

continued from page 8

The government will pay approximately 70 percent of the monthly premiums for beneficiaries who volunteer to participate in FEHBP-65. This will result in the beneficiary paying $100 to $300 per month out of pocket to participate – depending on the plan chosen. In addition, as the law currently reads, the beneficiary will be "locked out" from obtaining services at a military treatment facility, including pharmaceuticals.

More information on TRICARE Senior Prime and FEHBP-65 is available at, www.reg9.med.navy.mil.

efits education

Cancer patient gains hope with TRICARE access, quality

By Lt. Rick Haupt, USN

SAN DIEGO — Gail Regan gained new hope and the care she needed after enrolling in TRICARE Prime last fall at the Naval Medical Center here.

Regan, a 43 year-old Navy retiree, was diagnosed with cancer August after finding a lump on her sternum the month prior. The formal diagnosis was adenocarcinoma, primary unknown, meaning there was a malignant tumor at an unknown place elsewhere in her body. Regan's civilian health plan removed the lump, but was slow to test for the primary tumor, the source of her cancer.

Regan was scared.

Unnerved with waiting for further diagnostic care, she decided to enroll in TRICARE Prime at the Naval Medical Center in September.

"I had three exams the first day after I enrolled," she recalled, "and by the third day, I'd had a total of eight. The Navy really moved quickly."

Regan underwent exploratory surgery on Sept. 24. During the procedure, her surgeons diagnosed her with ovarian cancer and performed a complete hysterectomy. On October 2, she began chemotherapy.

"My experience with TRICARE here has been just great," she said. "The doctors spent so much time talking to me about my condition. They really took a personal interest in my case."

"Everyone was so nice," she said.

As a "stage four" cancer patient, Regan's condition was grave. The rapidity with which the disease spread was remarkable.

"My cancer antigens doubled from mid-August to mid-September," she said.

"We needed to work quickly to arrest my cancer."

Gail Regan is thrilled about her access to care with TRICARE Prime.

"I don't think anybody would work as hard as the staff did here," Regan said of the team that saved her life. "Ovarian cancer is very difficult to diagnose. There are no good screening tools. The symptoms are usually non-specific and this is a problem since early diagnosis is key in fighting cancer."

Following six months of chemotherapy, Regan is now undergoing radiation therapy to help prevent a relapse. She maintains a positive outlook.

"I feel I've regained control," she said. "There are no guarantees, but I've got a good long-term outlook."

Regan's experience motivated her husband, Kevin, to enroll in TRICARE Prime.

A former Marine, Kevin had long been a fan of Navy medicine. But as a commercial airline pilot, he, like Gail, had a civilian health plan. Now the two are outspoken fans of TRICARE.

The Regans, along with their two children, plan to move to Washington, D.C. in the summer to better accommodate Kevin's career. Although she'll miss the nurturing environment of Naval Medical Center, Regan is looking forward to the positive changes the move will bring her life.

Regan will use her TRICARE benefit at Walter Reed Army Medical Center.

"My doctor here has already spoken to my new doctor about me and my condition," she said. "He has a great reputation as a gynecological oncologist."

"I've been to Walter Reed when I was stationed in Washington," she said. "I really liked the hospital and the care available there. Like the medical center here, it has a top-notch bunch of people."